

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08646

8641

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 13 Cambridge		LENGTH OF STAY (in this place) 5 yrs. 6 mons.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hurlock X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Academy Street				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) (Middle) (Last) Annie Maria Bradley				4. DATE (Month) (Day) (Year) OF DEATH: September 3 19 55			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: March 25, 1865	9. AGE last birthday 90 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework		10B. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: William Goslee				14. MOTHER'S MAIDEN NAME: Sarah Ellen Leatherbury			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Lambertine C. Bradley, Federalsburg, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) DUE TO		450.0 GENERAL ARTERIOSCLEROSIS 10 YRS			
ANTECEDENT CAUSE (B)		(B) DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2 JAN 53 to 3 SEPT 55 that I last saw the deceased alive on 3 SEPT 55 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. SIGNATURE John H. H. H. H. ADDRESS Cambridge, Maryland DATE SIGNED Sept. 5, 1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 7, 1955		NAME OF CEMETERY OR CREMATORY Siloam Methodist Cemetery		LOCATION (City, town, or county) (State) Near Salisbury, Maryland	
DATE REC'D BY LOCAL REGISTRAR Sept. 7 1955		REGISTRAR'S SIGNATURE John H. H. H.		24. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Md.		ADDRESS	

RECEIVED
SEP 13 1955
BUREAU V. S.

8659

08647
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dorchester
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN (Rural) Cambridge		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN (Rural) Cambridge X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural, give location) /	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) SARAH (Middle) A (Last) CHESTER		(Month) Sept (Day) 8 (Year) 19 55	
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: May 25, 1903
9. AGE last birthday: 52 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer		10b. KIND OF BUSINESS OR INDUSTRY: Laundry	
11. BIRTHPLACE (State or foreign country): Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Farrare		14. MOTHER'S MAIDEN NAME: Harriett Askins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) -----		16. SOCIAL SECURITY No.: 161-07-9538	
17. INFORMANT & ADDRESS: Goldie Wilson, Grasonville, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
331X Immediate cause (a) Cerebral Hemorrhage DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		1 hour
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE John Moore Jr. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/9/1955 M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. 9/9/1955		
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF: 9/11/1955	NAME OF CEMETERY OR CREMATORY: Cordtown Cemetery
LOCATION (City, town, or county) (State): Dorchester County, Md.	24. FUNERAL DIRECTOR ADDRESS: Herbert M. St. Clair, Jr., Cambridge, Md.	
DATE REC'D BY LOCAL REG. Sept. 9, 1955	REGISTRAR'S SIGNATURE: John Moore Jr.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 81

SEP 18 1955

RECEIVED

8642

09706

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cambridge (Rural)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural, give location) <u>RFD # 1</u>			
3. NAME OF DECEASED: (Type or Print) <u>THELMA</u>		(First) <u>P.</u>		(Middle) <u>DAYTON</u>		(Last)	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>12-16-1917</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles W. Pilchard</u>				14. MOTHER'S MAIDEN NAME: <u>Not Known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. Raymond C. Dayton: Cambridge RFD#1, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				6 hrs. ?	
Immediate cause (a) <u>Viral encephalomyelitis & edema of the brain</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> stating underlying cause last (c) <u>advanced arteriosclerosis & coronary narrowing</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Eldridge H. Self</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-5-58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9-22-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	
LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 10 1955

BUREAU V. S.

8643

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08648

CERTIFICATE OF DEATH

Reg. Dist. No. 146

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 13 Cambridge		LENGTH OF STAY (in this place) 14 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hurlock - Rural X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 67 Cambridge-Maryland Hospital				STREET ADDRESS (If rural give location) Railroad Hill			
3. NAME OF DECEASED: (First) (Middle) (Last) Bessie Marie Dobson				4. DATE (Month) (Day) (Year) OF DEATH: September 25 1955			
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married	8. DATE OF BIRTH: February 10, 1912	9. AGE last birthday 43 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework		10B. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Abraham A. Farrare				14. MOTHER'S MAIDEN NAME: Josephine Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 3 No		16. SOCIAL SECURITY NO. 199-03-9443		17. INFORMANT & ADDRESS: John W. Dobson, Hurlock, Md., R.F.D.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Uremia							
ANTECEDENT CAUSE (S) Hypertensive Cardiovascular Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Renal Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May , 1955, to Sept. 25, 1955 that I last saw the deceased alive on Sept. 25, 1955 and that death occurred at 7:10 PM , from the causes and on the date stated above.							
SIGNATURE J. Edwin Fasset		J. EDWIN FASSETT, M.D.-227		Pine St-Camb., Md-9-28-55		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 28, 1955		NAME OF CEMETERY OR CREMATORY East New Market Cemetery		LOCATION (City, town, or county) (State) East New Market, Maryland	
DATE REC'D BY LOCAL REGISTRAR Sept. 28, 1955		REGISTRAR'S SIGNATURE John W. Dobson		24. FUNERAL DIRECTOR J.J. Frampton and Son		ADDRESS Federalsburg, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 5 1955

RECEIVED

8644

CERTIFICATE OF DEATH

Reg. Dist. No. 176

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50</u> <u>Washington Street</u>	STREET ADDRESS (If rural give location) <u>1</u> <u>Washington Street</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) DECEASED: (Type or Print) <u>MARY</u> <u>ELIZABETH</u> <u>FOWLER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>SEPT</u> <u>15</u> <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>7-21-1890</u>
9. AGE last birthday <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>R. Asbury Snelling</u>		14. MOTHER'S MAIDEN NAME: <u>Annie R. Bosman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr. Joseph S. Fowler: Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>5 min.</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerosis Generalized</u>			<u>1 year</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u>			
(C) <u>Diabetes Mellitus</u>			<u>1 week</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-8-55</u> , 19 <u>55</u> , to <u>9-15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-15</u> , 19 <u>55</u> , and that death occurred at <u>0:15</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Eldridge H. Hoff MD</u>		M. D. <u>Cambridge Md</u> DATE SIGNED <u>9-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-18-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 18, 1955</u>		REGISTRAR'S SIGNATURE <u>John S. Hall, Jr. MD</u>	
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. 1

SEP 28 1955

RECEIVED

8645

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>20yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>13</u> <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u> <u>Cambridge Md Hospital</u>				STREET ADDRESS (If rural give location) <u>208 Washington St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Pauline</u> <u>N.</u> <u>Garrison</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>9</u> <u>10</u> <u>19 55</u>				
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>June 22, 1928</u>	9. AGE last birthday <u>27</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Accomac Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Horace Garrison</u>				14. MOTHER'S MAIDEN NAME: <u>Sallie Coston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>1</u> - - -		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) - - -		17. INFORMANT & ADDRESS: <u>208 Wash., St</u> <u>Mrs. Sallie Garrison-Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary embolism</u>						<u>8hrs</u>	
ANTECEDENT CAUSE (S): DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <u>Childbirth</u>						<u>full term</u>	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 3, 1955</u> to <u>Sept 10, 1955</u> that I last saw the deceased alive on <u>Sept 10, 1955</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Edwin Fasset</u>		J. EDWIN FASSETT, M.D.		ADDRESS <u>227 Pine St-Camb., Md.</u>		DATE SIGNED <u>9-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge-Dor- Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 15, 1955</u>		REGISTRAR'S SIGNATURE <u>J. H. H. H.</u>		24. FUNERAL DIRECTOR <u>H.M. StClair, Jr.-Camb., Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF COMMERCE

BUREAU A.

SEP 20 1955

RECEIVED

[Handwritten signature]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8646

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08651
Reg. Dist.

No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>Few hours</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Elliotts</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge, Maryland Hospital</u>		STREET ADDRESS (If rural, give location) <u>7</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Ira</u>	(Middle) <u>Edwin</u>	(Last) <u>Gray</u>	(Month) <u>9/</u> (Day) <u>14/</u> (Year) <u>55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 22, 1900</u>
9. AGE last birthday: <u>55</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Waterman</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Davie Gray</u>		14. MOTHER'S MAIDEN NAME: <u>Deltha Ann --</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Elliotts, Md.</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Phyllis H. Gray - wife</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
<u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			<u>5 Min.</u>
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>John Moore</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/17/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>9/17/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Elliotts Cemetery</u>	LOCATION (City, town, or county) (State): <u>Elliotts, Maryland</u>
DATE REC'D BY LOCAL REG: <u>Sept. 17, 1955</u>	REGISTRAR'S SIGNATURE: <u>John Moore</u>	24. FUNERAL DIRECTOR: <u>Ruth S. Willoughby</u> ADDRESS: <u>East New Market, Md.</u>	

SEP 29 1955

BUREAU V. 2

RECEIVED

8660

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>rural Cambridge</u>		<u>6 yrs.</u>		OR TOWN <u>Galestown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept. 14</u> <u>1955</u>			
5. SEX: <u>male</u>				6. COLOR OR RACE: <u>white</u>			
7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>single</u>				8. DATE OF BIRTH: <u>3/24/14</u>			
9. AGE last birthday: <u>41</u> yrs.				10. IF UNDER 1 YEAR: Months Days Hours Mln.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
11. BIRTHPLACE (State or foreign country): <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>Walter E. Hastings</u>				14. MOTHER'S MAIDEN NAME: <u>Katie Oliphant</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital records</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic Epidemic Encephalitis</u>							
DUE TO							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/15</u> , 19 <u>52</u> , to <u>9/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 14</u> , 19 <u>55</u> and that death occurred at <u>11:20</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Pringle</u>				DATE SIGNED <u>9/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. FUNERAL DIRECTOR <u>Paul J. Smith</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Sept 16, 1955</u>				ADDRESS <u>Galestown, Md.</u>			
REGISTRAR'S SIGNATURE <u>John H. D.</u>				ADDRESS <u>Haystack, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 19 1955

BUREAU V. S.

8661

08653
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Dorchester</u>	MARYLAND		STATE <u>Md.</u>	COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Cambridge</u>	LENGTH OF STAY (In this place) <u>15 Mo.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Avalon</u>	<u>208-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hosp</u>			STREET ADDRESS (If rural, give location) <u>✓</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Ernest A. Jenkins</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 25 1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>8-5-1875</u>		9. AGE last birthday: <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Seafood</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>West Jenkins</u>			14. MOTHER'S MAIDEN NAME: <u>Charlotte ?</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <u>Hospital Records</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<u>3 wks.</u>	
Immediate cause (a) <u>Bronchopneumonia</u> DUE TO Antecedent cause(s) (b) <u>Fracture tibia</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>8 wks.</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Hospital</u>	21c. (City or town) (County) (State) <u>Cambridge Dorchester Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8-1-1955 1PM.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell out of bed.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John M. H.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9-25-1955</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Sept. 29, '55</u>	NAME OF CEMETERY OR CREMATORY <u>Tilghman Cemetery</u>	LOCATION (City, town, or county) <u>Talbot Md.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>Sept 26, 1955</u>	REGISTRAR'S SIGNATURE <u>John M. H.</u>	24. FUNERAL DIRECTOR <u>Hambleton Harrison</u>		ADDRESS <u>St. Michaels</u>	

RECEIVED

SEP 27 1955

BUREAU V. S.

8662

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Cambridge (Rural)</u>		<u>45 yrs</u>		TOWN <u>Cambridge (Rural)</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD # 2</u>				STREET ADDRESS (If rural give location) <u>RFD # 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>AUGUST</u> <u>FREDERICK</u> <u>KNAUER</u>				OF DEATH: <u>SEPT</u> <u>9</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>8-11-1866</u>	<u>89</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own General Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Grunbach, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Matthew Knauer</u>				14. MOTHER'S MAIDEN NAME: <u>Not Known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>none</u>		17. INFORMANT & ADDRESS: <u>Md. Mrs. Margaret F. Knauer; Cambridge RD 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>30 min</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Serumia</u>						<u>2 whs</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 1955, to <u>Sept</u> , 1955, that I last saw the deceased alive on <u>Sept 8</u> , 1955, and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Cambridge, Md.</u>		DATE SIGNED <u>9-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-12-1955</u>		<u>Dorchester Memorial Park</u>		<u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 12, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR		ADDRESS	
				<u>LeCompte Funeral Service</u>		<u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

SEP 14 1955

RECEIVED

8647

MARYLAND STATE DEPARTMENT OF HEALTH

08655

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Vienna, Maryland</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge, Md.</u>		STREET ADDRESS (If rural, give location) <u>/</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Kendall</u>	(Middle) <u>Francis</u>	(Last) <u>Maddox</u>
4. DATE OF DEATH	(Month) <u>Sept.</u>	(Day) <u>6,</u>	(Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/2/1897</u>
9. AGE last birthday <u>58</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Thomas Maddox</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Flossie Maddox, wife</u>		<u>Vienna, Md.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
331X Immediate cause (a) <u>Cerebral Hemorrhage</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>9/9/55</u>	<u>Dor. Memorial</u>	<u>Cambridge Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Sept. 8, 1955</u>	<u>J. H. Law, Jr.</u>	<u>Arthur S. Willoughby</u>	<u>East New Market, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 13 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 46

8648

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>8</u> mons	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wingate</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Muse Street</u>		STREET ADDRESS (If rural give location) <u>P.O.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>JOHN</u>	(Middle) <u>T</u>	(Last) <u>MOORE</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>6-4-1872</u>	
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Waterman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Fishing Indust.</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John E. Moore</u>		14. MOTHER'S MAIDEN NAME: <u>Priscilla Woodland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Oval Moore: Toddville, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>190X Metastatic melanotic</u>		<u>10 months</u>	
ANTECEDENT CAUSE (S): <u>Melanoma (lip)</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/10</u> , 19 <u>54</u> , to <u>9/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/1</u> , 19 <u>55</u> , and that death occurred at <u>WTA M</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>Cambridge Md</u>	
DATE SIGNED <u>9/8/55</u>		M. D. <u>Cambridge Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-4-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept 4, 1955</u>		REGISTRAR'S SIGNATURE <u>John Hall, Jr. D.</u>	
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

SEP 14 1963

RECEIVED

8649

CERTIFICATE OF DEATH

Reg. Dist. No. 116.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cambridge		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Md. Hospital				STREET ADDRESS (If rural give location) Cross Street			
3. NAME OF DECEASED: (First) (Middle) (Last) BABY GIRL PERRY				4. DATE (Month) (Day) (Year) OF DEATH: Sept. 14, 1955			
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single	8. DATE OF BIRTH: Sept. 14, 1955	9. AGE last birthday yrs. 13	IF UNDER 1 YEAR Months 13	IF UNDER 24 HRS. Days 1	Hours 13 Min. 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Perry				14. MOTHER'S MAIDEN NAME: Mary Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Thomas Perry, Cambridge, Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 776X				2 hrs. 20 min.			
ANTECEDENT CAUSE (S) Prematurity							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-14-1955 to 9-14-1955 , that I last saw the deceased alive on 9-14-1955 , and that death occurred at Cambridge, Md. from the causes and on the date stated above.							
SIGNATURE John H. Hall, M.D.		DATE SIGNED 9-15-55		ADDRESS Cambridge, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/15/1955		NAME OF CEMETERY OR CREMATORY Waugh Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland.	
DATE REC'D BY LOCAL REGISTRAR Oct. 20, 1955		REGISTRAR'S SIGNATURE John H. Hall, M.D.		24. FUNERAL DIRECTOR Herbert M. St. Clair, Jr.		ADDRESS Cambridge, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 21 1955

RECEIVED

8650

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>1</u> week		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD # 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) CARL AXEL R. PETERSON				4. DATE (Month) (Day) (Year) OF DEATH: SEPT 20 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 5-2-1890	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer		10B. KIND OF BUSINESS OR INDUSTRY: Own General Farm		11. BIRTHPLACE (State or foreign country): Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Johann B. Peterson				14. MOTHER'S MAIDEN NAME: Not Known			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) 301-10-7520		17. INFORMANT & ADDRESS: Mrs. Ellen P. Mc Lane: Crisfield, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Coronary Artery Thrombosis</u>						2 hours	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerosis</u>						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Post operative Cystotomy</u>						5 days	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/16</u> , 19 <u>55</u> , to <u>9/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>55</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. SIGNATURE <u>H. H. Banks</u> ADDRESS <u>M. D. Cambridge Md</u> DATE SIGNED <u>9/22/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-23-1955		NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR Sept. 23, 1955		REGISTRAR'S SIGNATURE Gold & Grace, H. D.		24. FUNERAL DIRECTOR LeCompte Funeral Service		ADDRESS Cambridge, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 26 1966

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08661

8651

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Cambridge (Rural)		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge (Rural) X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. #2 Cambridge, Md				STREET ADDRESS (If rural give location) R.F.D. #2 Cambridge, Md			
3. NAME OF DECEASED: (Type or Print) WILLIAM RIDEOUT				4. DATE OF DEATH Sept 27, 1955			
5. SEX: Male		6. COLOR OR RACE: Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: Sept 1, 1886	
9. AGE last birthday 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer		10B. KIND OF BUSINESS OR INDUSTRY: Farming		11. BIRTHPLACE (State or foreign country): Dorchester Co., Md	
13. FATHER'S NAME: James Rideout				14. MOTHER'S MAIDEN NAME: Mary Elizabeth Rideout			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS: Florence Pinder, RFD 2, Cambridge, Md	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Hemorrhage							
ANTECEDENT CAUSE (S) (B) Arteriosclerotic Heart Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) -----							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. -----							
19A. DATE OF OPERATION: Sept 27, 1955				19B. MAJOR FINDINGS OF OPERATION -----			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -----			
22. I hereby certify that I attended the deceased from July 4, 1955 to Sept. 27, 1955 that I last saw the deceased alive on Sept. 27, 1955 , and that death occurred at M. from the causes and on the date stated above.							
SIGNATURE J. EDWIN FASSETT		ADDRESS 227 Pine St-Camb., Md.		DATE SIGNED 28 Sept 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/30/1955		NAME OF CEMETERY OR CREMATORY Salem Cemetery		LOCATION (City, town, or county) (State) Salem, Maryland	
DATE REC'D BY LOCAL REGISTRAR Sept 30, 1955		REGISTRAR'S SIGNATURE John Hall, Jr.		24. FUNERAL DIRECTOR Herbert M. St. Clair, Jr.		ADDRESS Cambridge, Md	

BUREAU V. S.

OCT 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08662

8652

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 13 Cambridge		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 13 Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 24 Center Street				STREET ADDRESS (If rural give location) 24 Center Street			
3. NAME OF DECEASED: (First) (Middle) (Last) Frank John Roberts				4. DATE OF DEATH: (Month) (Day) (Year) 9 21 19 55			
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: March 5, 1905	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Junk		11. BIRTHPLACE (State or foreign country): Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Roberts				14. MOTHER'S MAIDEN NAME: Millie James			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) -----		16. SOCIAL SECURITY NO. 214-07-8087		17. INFORMANT & ADDRESS: Sarah Roberts, Cambridge, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.0							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Cerebral Hemorrhage							
DUE TO							
(B) Arteriosclerotic Heart Disease							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 7, 1955 to Sept. 21, 1955 , that I last saw the deceased alive on Sept. 21, 1955 , and that death occurred at M , from the causes and on the date stated above.							
SIGNATURE Edwin Fasset		J. EDWIN FASSETT, M.D.		227 Pine St-Camb., Md.		DATE SIGNED -9-21-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/25/1955		NAME OF CEMETERY OR CREMATORY Bethel Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR Sept 24, 1955		REGISTRAR'S SIGNATURE John H. D.		24. FUNERAL DIRECTOR Herbert M. St. Clair, Jr.		ADDRESS Cambridge, Md.	

BUREAU V. S.

SEP 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8653 CERTIFICATE OF DEATH

Reg. Dist. No. **08663**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) 13 TOWN Cambridge		LENGTH OF STAY (in this place) 3yrs		CITY (If outside corporate limits, write RURAL and give nearest town) 13 TOWN Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 317 High Street				STREET ADDRESS (If rural give location) 317 High Street			
3. NAME OF DECEASED: (Type or Print) Bertha Nixon St.Clair				4. DATE (Month) (Day) (Year) OF DEATH: Sept. 15, 1955			
5. SEX: Female		6. COLOR OR RACE: Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: Dec. 17, 1894	
				9. AGE last birthday 60 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 15 Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife				10B. KIND OF BUSINESS OR INDUSTRY: Home Making		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: Alfred Nixon				14. MOTHER'S MAIDEN NAME: Martha Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS: Florence St. Clair, Salisbury, Md.							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.0 Cerebral Hemorrhage							
ANTECEDENT CAUSE (S) Arteriosclerotic heart disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. Epileptiform Seizures							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May , 1953 to Sept. , 1955 that I last saw the deceased alive on Sept. 15, 1955 , and that death occurred at 4:00 M, from the causes and on the date stated above.							
SIGNATURE J. Edwin Fassett		ADDRESS 227 Pine St., Camb., Md.		DATE SIGNED 9-15-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/18/1955		NAME OF CEMETERY OR CREMATORY Waugh Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR Sept 18, 1955		REGISTRAR'S SIGNATURE John Thaw, Jr.		24. FUNERAL DIRECTOR ADDRESS Herbert M. St. Clair, Jr., Cambridge Md.			

RECEIVED

SEP 20 1955

BUREAU V. S.

8654

08664
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Dorchester		STATE		Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		TOWN		CITY (If outside corporate limits write RURAL and give nearest town)		TOWN	
13		Cambridge		13		Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
60 311 Maryland Ave.				311 Maryland Ave.			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		Irving		Francis		Shepherd	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		White		Married		June 11, 1901	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday:		4. DATE OF DEATH	
Insurance				54 yrs.		Sept. 7, 1955	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Maryland		USA		Months Days		Hours Min.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
James M. Shepherd				Emma Hickman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
no				214-10-9517			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
Mrs. Sarah Shepherd Cambridge, Md.				19. DATE OF OPERATION:			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a).....				15 Min.	
DUE TO					
Antecedent cause(s) (b).....					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:				20. AUTOPSY?	
19b. MAJOR FINDING OF OPERATION:				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
John M. Wood		DEPUTY MEDICAL EXAMINER		Sept. 7, 1955	
M. D.		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Sept. 9, 1955		Cambridge Cemetery	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR		ADDRESS	
Cambridge, Md.		Kenneth R. Thomas		Cambridge, Md.	
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE			
Sept. 7, 1955		John M. Wood			

BUREAU V. 8

SEP 29 1955

RECEIVED

8663

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Re 8665

No. 116

1. PLACE OF DEATH:

COUNTY Dorchester MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cambridge
 TOWN Cambridge LENGTH OF STAY (In this place) 1 month

HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Dorchester
 CITY (If outside corporate limits write RURAL and give nearest town) Cambridge
 TOWN Cambridge

STREET ADDRESS (If rural, give location) Maryland Ave. ext.

3. NAME OF DECEASED: (Type or Print) <u>Russell Phillips Smith</u>			4. DATE OF DEATH <u>Sept. 15, 1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 14, 1877</u>	9. AGE last birthday: <u>78</u> yrs.	10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Register of Wills</u>			11. BIRTHPLACE (State or foreign country): <u>Cambridge, R.D.</u>		
13. FATHER'S NAME: <u>Edward P. Smith</u>			14. MOTHER'S MAIDEN NAME: <u>Mary E. Cantville</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>			16. SOCIAL SECURITY No.: <u>none</u>		
17. INFORMANT & ADDRESS: <u>Mrs. Lelia B. Smith, Cambridge, Md.</u>			18. MEDICAL CERTIFICATION		

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral Thrombosis
 DUE TO

Antecedent cause(s) (b) Arterio sclerosis
 Diseases or conditions, if any, giving rise to the above cause DUE TO
 stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

2 days?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Fracture Neck R. Femur

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>)	21c. (City or town) <u>Cambridge, Dorchester, Maryland</u> (County) <u>09</u> (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/23/55, 1:00P M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Slipped and fell on floor.</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John Moore

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Sept. 16, '55
 DEPUTY MEDICAL EXAMINER ☒
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF: Sept. 17, 1955 NAME OF CEMETERY OR CREMATORY: East New Market Cemetery LOCATION (City, town, or county) (State): East New Market, Md.

DATE REC'D BY LOCAL REG. Sept. 16/1955 REGISTRAR'S SIGNATURE John Moore, M.D.

24. FUNERAL DIRECTOR Kenneth R. Thomas, Cambridge, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 19 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08666

8655

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
OR TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>entire life</u>	OR TOWN <u>Cambridge</u>	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>403 Race St.</u>		STREET ADDRESS <u>403 Race St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Ruth Hastings Smith</u>		OF DEATH: <u>Sep. 5, 1955</u> <u>19</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 14, 1896</u>
9. AGE last birthday <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Cambridge</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>George A. Hastings</u>		14. MOTHER'S MAIDEN NAME: <u>Nellie Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>44</u>	
17. INFORMANT & ADDRESS: <u>Geo. O. Smith, Cambridge, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinomatosis, abdominal</u>		<u>1 yr. (?)</u>	
ANTECEDENT CAUSE (B) <u>Possible carcinoma of ovary</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>June 15, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Abdominal carcinomatosis</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 10, 1955</u> to <u>Sept. 5, 1955</u> , that I last saw the deceased alive on <u>Sept. 5, 1955</u> , and that death occurred at <u>12.45 P.</u> from the causes and on the date stated above.			
SIGNATURE <u>Lewis M. Burdette</u>		ADDRESS <u>M. D. Cambridge, Md.</u>	
DATE SIGNED <u>Sept 6, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 7, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-6-1955</u>		REGISTRAR'S SIGNATURE <u>John H. H. H.</u>	
24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>		ADDRESS	

BUREAU V. 1

8 1955

RECEIVED

8656

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Cambridge</u>		LENGTH OF STAY <u>since this place</u> <u>5/20/54</u>		CITY (If outside corporate limits, write TOWN and give nearest town) <u>Hillsboro</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS <u>Box 28</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Dora Heath States</u>				DEATH: <u>Sept. 4 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Jan. 3, 1872</u>	9. AGE last birthday <u>83</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME: <u>William Heath</u>				14. MOTHER'S MAIDEN NAME: <u>Dora Elizabeth Lilly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT & ADDRESS: <u>E.S.S.H. Records</u>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>							<u>several</u>
DUE TO							<u>years</u>
ANTECEDENT CAUSE (S) (B) <u>Generalized Arteriosclerosis</u>							<u>several</u>
DUE TO							<u>years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u>							<u>several</u>
							<u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Paranoia</u>							<u>about 4</u>
							<u>years</u>
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/20</u> , 19 <u>54</u> , to <u>9/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>55</u> , and that death occurred at <u>11:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Reddick</u> M.D.				DATE SIGNED <u>Sept. 4, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Hillsboro, Ind.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-7-55</u>		REGISTRAR'S SIGNATURE <u>John H. H. H.</u>		24. FUNERAL DIRECTOR <u>Charles H. H. H.</u>		ADDRESS <u>Hillsboro, Ind.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 8 1955

RECEIVED

8657

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dorchester
CITY (If outside corporate limits, write RURAL OR and give nearest town) 13 TOWN Cambridge	LENGTH OF STAY (in this place) 27 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR 13 TOWN Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 103 Willis St.,		STREET ADDRESS (If rural give location) 103 Willis St.,	
3. NAME OF DECEASED: (First) (Middle) (Last) BIRDIE R. TODD		4. DATE (Month) (Day) (Year) OF DEATH: 9 25 19 55	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M	8. DATE OF BIRTH: 11/3/1889
9. AGE last birthday 65 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant		10B. KIND OF BUSINESS OR INDUSTRY: General mercantile	
11. BIRTHPLACE (State or foreign country): Bishops Head, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: James E. Todd		14. MOTHER'S MAIDEN NAME: Sarah Powley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. 214 07 7379	
17. INFORMANT & ADDRESS: 103 Willis St., Mrs. Millicent Jones Todd Cambridge, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Curious of liver			5-20-55
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Rheumatic fever			50 yr 2 mo
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/25 , 19 55 , to 9/25 , 19 55 , that I last saw the deceased alive on 9/25 , 19 55 , and that death occurred at 11 A. M. from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS Cambridge Md. DATE SIGNED 9/27/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/27/55	
NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		LOCATION (City, town, or county) (State) Cambridge, Md.	
DATE REC'D BY LOCAL REGISTRAR Sept 27 1955		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 81

OCT 18 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8658 08668

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dorchester
CITY (If outside corporate limits, write RURAL OR and give nearest town) 13 TOWN Cambridge	LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR 13 TOWN Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 457 High St		STREET ADDRESS (If rural give location) 457 High St	
3. NAME OF DECEASED: (First) (Middle) (Last) William Ward		4. DATE (Month) (Day) (Year) OF DEATH: 9 14 19 55	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower	8. DATE OF BIRTH: Oct. 12, 1891
9. AGE last birthday 63 yrs.		IF UNDER 1 YEAR Months 11 Days 2	IF UNDER 24 HRS. Hours 1 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10B. KIND OF BUSINESS OR INDUSTRY: Food Packing	11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Thomas Ward	
14. MOTHER'S MAIDEN NAME: Emily Wilson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes	
16. SOCIAL SECURITY NO. 220-10-6883		17. INFORMANT & ADDRESS: Elizabeth Stafford: Cambridge, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 420.0			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Cerebral Hemorrhage			
DUE TO			
(B) Arteriosclerotic Heart Disease			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June, 1953 , to Sept 14, 1955 , that I last saw the deceased alive on Sept. 14, 1955 , and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE Edwin Fasset		DATE SIGNED 9-16-55	
EDWIN FASSETT, M.D.		227 Pine St-Cambridge, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/18/1955	Bethel Cemetery	Cambridge, Md.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 19, 1955	John Hall, Jr.	Herbert M. St. Clair, Jr.	Cambridge, Md.

BUREAU V. B.

SEP 28 1925

RECEIVED